EXPECARE FAMILY CARE URGENT CARE OF TEXAS

Injectafer Order Form
(ferric carboxymaltose)

FAX TO: 817-472-7213

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

PRIMARY & SECONDARY ICD 10 CODES REQUIRED

Primary ICD 10 Code

☐ D50.9 Iron Deficiency Anemia, Unspecified

☐ D50.0 Iron Deficiency Anemia Secondary to Blood Loss (chronic)

Other: _____

Secondary ICD 10 Code *(Underlying Condition - Required)*

Other: _____

***REQUIRED*: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
***LAB RESULTS:* Hemoglobin & Hematocrit levels within last 30 days. Other iron studies as available: Serum iron, total iron binding capacity (TIBC), serum ferritin, and transferring saturation within last 30 days.**

PRESCRIPTION*

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IVP
☐ Famotidine: 20 mg PO
☐ Methylprednisolone: 125 mg SIVP
Other: _____

INJECTAFER (ferric carboxymaltose)

Diluted in 250 mL** of 0.9% Sodium Chloride as directed over at least 30 minutes via pump

Loading Dose

IV: (wt < 50 kg): Infuse 15 mg/kg dose twice, separated by at least 7 days
** **Doses less than 500 mg require dilution in 100 mL of 0.9% Sodium Chloride**

Patient Weight: _____ lbs. **or** _____ kg

IV: (wt > 50 kg): Infuse 750 mg dose twice, separated by at least 7 days

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____